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BEFORE THE

FIRST COAST HEALTHCARE EXECUTIVES GROUP LUNCHEON

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Introduction

- I'm glad to be here.....

- To begin, I'd like to take us back before World War I and paint a verbal picture of beautiful Washington state.
    * In fact, the year is 1910, and there is an abundance of tall, stately trees.
    * The air is crisp and clean. The sky is blue and clear.
    * Now picture two doctors — Thomas Curran and James Yocum — meeting with representatives of the lumber industry.
    * They are designing one of the very first pre-paid medical practices — as HMOs were formerly known.
    * In their contract, they agree to cover employee health care for 50 cents per member per month.
    * And thus, the "managed care" industry was born.

- Obviously, a lot has changed in the health care industry since that day in 1910.

- I appreciate this opportunity to share my observations on where we are today, what I see happening down the road, and where Blue Cross and Blue Shield of Florida fits into the picture.

The Health Care Industry's Evolution

- The health care industry has undergone some dramatic changes, particularly in the last ten years. And today, these changes are continuing to take place at an increasingly faster pace.

- These changes are far-reaching and affect every aspect of the industry — the delivery system, financing, medical technology and the growing use of information as a dimension of competition.

- One of the biggest shifts we're seeing is in the growth of managed care. The marketplace is clearly shifting from indemnity to managed care — here in Florida and across the nation.
    * Nationwide, more than 58 million Americans have HMO health care coverage (AAHP statistic).
    * In Florida alone, more than 4 million people are enrolled in an HMO (statistic cited in *Orlando Business Journal* 9/23/96).
- This shift in the marketplace has been voluntary and seemingly triggered by cost:
    * More than 80% of Floridians who obtain benefits from their employers have chosen an HMO over at least one other option. (Foster Higgens' Nat'l Survey of Employer-Sponsored Health Plans Report, 1995).
    * Consumers (employers in particular) seem to be reacting to 10-15 years of accumulative sharp price increases rather than the availability of the HMO.
- Innovative health care programs that focus on coordinated care like that in an HMO have contributed to a 20-year low in the national medical inflation rate.
    * For the last two years, health care costs grew by only 2.5% per year (*Associated Press*, 4/10/97) — quite a contrast to the double-digit increases of the 1970s and mid-1980s.
- Employers and individual consumers are finding that affordability and quality **do** go together.
    * GTE says their data shows the highest quality health plans with the highest member satisfaction are also the most cost-effective.
    * Numerous independent studies have consistently shown that more HMO subscribers are satisfied with their health care than those in fee-for-service plans.
- The growth of managed care is changing the delivery system. For example:
    * The use of skilled nursing facilities and home health agencies has resulted in declining hospital utilization.
    * In the early 1980s, we had an inpatient utilization rate of 750 days per 1,000 members per year. We were talking about starting an HMO and expecting it to be profitable if we could achieve 350 inpatient days per 1,000 members per year. It was a big reach and we said it was impossible. Today, these plans would all be broke if they had 350 days per 1,000 members per year.
    * And, provider-sponsored health management plans are entering the market.

- All of these changes are occurring in a highly competitive market.
    * Large, national companies with deep pockets, like United HealthCare, are entering the Florida market.
    * While Florida insurance companies, like Gulf Life and Independent Life, are closing down their operations.

- Reported mergers and acquisitions make daily headlines. Just to mention a few of the Florida-related deals from the first quarter of this year:
    * On January 24th, PacifiCare Health Systems announced it had signed an agreement to sell its Florida subsidiary to Total Health Choice, the newly-formed Florida subsidiary of the Michigan-based HMO Total Health Care.
    * On January 15th, Columbia/HCA Healthcare Corp., said it would buy Value Health Inc., a Florida managed care company that specializes in prescription drugs, workers' compensation and mental health services.
    * In Jacksonville, on January 17th, FPIC Insurance Group, Inc., through its subsidiary McCreary Corporation, completed the acquisition of Employers Mutual Inc. — a company that administers self-insured managed care health plans in Florida and Texas.
    * And, also in Jacksonville, Baptist/St. Vincent's Health System signed a letter of intent on March 8th to purchase the Visiting Nurse Association, the largest provider of home health care services in Northeast Florida.
    * I could go on, but I think you get the picture.

Customer Needs also are Evolving

- In tandem with the changing market dynamics, customer needs for health care also are evolving. Let me separate "customer" into two groups — the first being employers and the second individual consumers.

- Providing health care benefits to employees is a significant cost of doing business. And employers today are pretty specific in what they want:
    * They are demanding cost containment and are increasingly willing to trade broad choice for lower cost;
    * They are seeking clear demonstrations of medical quality and improved outcomes; and
    * Employers are increasingly sensitive to the customer service their employees receive.

- Individual consumers, on the other hand:
    * Are faced with paying a larger share of health costs;
    * While they generally prefer broad provider networks, they are increasingly willing to trade choice for cost; and
    * Consumers continue to have a limited understanding of health insurance and tend to be frustrated with service provided in traditional indemnity plans.
- At a high level, this is how I see the industry — as it has evolved and where we are today. Now, what about the future?

A Look at the Future

- To describe what I see happening in the future, I'd like to touch on five areas I believe will have a strong influence.
- First, I see the shift to managed care continuing.
- Unfortunately for those of us in the business, the customer doesn't always see this shift the same way we do.
    * We had a very neat way of dealing with the demand for HMOs, PPOs, etc. We had a product line we used to call the "Triple Option" — you could buy a traditional indemnity product; you could buy a PPO; and you could buy an HMO.
    * Some years ago, customers decided they didn't like it that way. They wanted *Feature A* out of the traditional plan, *Feature B* out of the PPO, and *Feature C* out of the HMO.
    * As a result, there are a lot of hybrid products out on the market today.
- What will we have in the future? We're not sure. We do believe that whatever it is will have a strong managed care component. It might be called HMO; it might not be called HMO. But whatever its name, it will certainly have managed care characteristics.
- I also believe that the use of managed care in government-sponsored programs like Medicare and Medicaid will continue to increase.
    * The government says Medicare is going to go broke in the year "x." Medicaid funding is constantly being cut back.

- **Second**, the needs, values and expectations of our customers — employers and individual consumers — will continue to evolve.
    * And, again, they probably won't see things in the neat little components and packages we do.

- Employer-driven health care looks like the system of choice for the foreseeable future. And employers — large and small — are increasingly turning to managed care.
    * In response to enrollment gains and satisfaction indices that continue to show the value and quality of HMOs, Blue Chip companies like American Express, Xerox and IBM are purchasing HMO services for their employees.
    * While small employers believe that providing their employees with quality health care is important, many found the high cost of traditional indemnity insurance was beyond their reach. HMOs have provided them with an affordable alternative for quality care.

- **Third,** I believe the delivery system will continue to consolidate and integrate — both horizontally and vertically.

- Health care will be delivered through an integrated system. Not necessarily a single physical location, but one that connects primary, specialty and ancillary care, hospitals, managed care companies and consumers in an organized, coordinated way — a way that makes sense to individuals going through the system.

- And, as this evolution of the delivery system continues, multiple issues such as risk management, finance, governance and regulation will have to be resolved.

- **Fourth,** Wall Street and increasing competition will continue to be a significant area of influence.

- Wall Street will continue to play a major role in shaping the health care industry:
    * "For-profit" corporations such as Columbia/HCA are rapidly acquiring hospitals, ambulatory care centers and other ancillary components of the delivery system;
    * The number of "for-profit" HMOs is growing;
    * And, several BC/BS plans have been or are in negotiations to be acquired.

- Competition will continue to increase. For example, I think we will see an increasing number of provider-sponsored health management plans entering the market — especially as a vehicle for government to reduce its health care costs in the Medicare and Medicaid programs.

- The basis of competition is moving beyond cost and access. Five or ten years ago, health care purchasing decisions were driven by a search for low prices and concentrated volume.

Today, purchasers demand superior customer satisfaction and improved health outcomes for employees.

- And, **fifth,** health care reform — insurance, tort, Medicaid, Medicare, etc. — will continue to influence the evolution of our health care system. While no one can predict for certain the outcome of reform efforts at the state or federal levels, we certainly put a lot of faith in the certainty that private market solutions will play a major role in reform.

- Having said all that — about the past, present and future direction of health care — where does Blue Cross and Blue Shield of Florida fit into the picture?

The Role of BCBSF

- In the 30 years I've been at Blue Cross and Blue Shield of Florida, I've certainly seen a lot of change. I've seen a lot of change in just the last few years alone. And, I venture to say if I can stay there for a few more years, I'll continue to see even more change.

- One of the more significant changes was our decision in the late 1970s to begin developing managed care capabilities. We were very optimistic because we had predicted that upwards of 20% of the population would enroll in an HMO or managed care product. Every one said it wouldn't happen. Today, 83% of our customers are enrolled in one of our HMO or PPO plans.

- While we are proud to have the largest HMO (Health Options) and PPO in the state, we are even more proud to be a leader in providing Floridians with access to affordable, quality health care that promotes health and wellness.

- The statistics demonstrate managed care's coordinated approach holds great promise for Americans' future health. Government statistics show that:

    * Women enrolled in HMOs are more likely to obtain mammograms than women enrolled in fee-for-service plans;

    * Babies born through managed care programs are much healthier than the national average; and

    * Managed care patients with cancer are diagnosed and treated earlier than patients in fee-for-service plans.

- Results like these are possible because managed care plans take a partnership approach to their members' care.
    * Sophisticated information systems allow doctors to track which patients need cancer screenings and other important tests. And, as a major change, these programs also remind their patients to obtain these services on schedule.
    * And, just as important, managed care plans encourage their members to play a greater role in making decisions about their health care by working directly with their personal physicians.
- Managed care plans also provide special programs to help patients with chronic illnesses such as diabetes or asthma regain control of their lives. For example:
    * Studies show that repeated visits to the emergency room for childhood asthma are not only costly and unnerving for families, but they do little to teach patients how to avoid attacks.
    * Within the managed care concept, physicians, nurses, health educators and patients work together to establish a self-management plan for the patient that includes monitoring airway flow and evaluating their environment to eliminate triggers that can set off an attack.
    * Patients become <u>active</u> participants in taking control of their own condition and improving their health — rather than being <u>passive</u> victims of their illness.
    * This kind of teamwork is <u>impossible</u> in the fragmented fee-for-service environment.
- Managed care plans also offer expanded benefits to the elderly. These plans allow seniors to access comprehensive health care services that focus on prevention with small out-of-pocket charges. This approach allows doctors to detect a patient's health problems early, improving their quality of life by treating problems *before* they become major, life-threatening illnesses.
- These are some of the reasons why we are continuing to invest in building managed care capabilities.
- These are also some of the reasons why we continue to actively work with our customers, industry partners and other concerned Floridians when legislation is proposed at the state or federal level that would undermine or destroy the managed care concept. Legislation, for example, like "direct access."
- If signed into law, direct access legislation — such as that recently passed in the state legislature — will undermine the role of the family doctor in monitoring and supervising each patient's overall care. It will increase costs. And, it will limit — not improve — consumer choice.

- HMOs use a family doctor to make sure each patient gets the right care, from the right doctor, at the right time. This reduces unnecessary or duplicative procedures.

- Is it always perfect? I'm sure it's not. Is it better than the previous system? I believe the statistics show that it is.

- Direct access will kill this essential component of HMO health plans and increase the average HMO premium by up to 14% — that's more than $500 per year for a family of four (according to a Wyatt & Co. study).

- Under a direct access mandate, consumers, in effect, would be denied the option of choosing managed care — a concept that millions of Americans have chosen over other options because managed care has proven to be both high quality and affordable.

- We will be asking the governor to veto this costly legislation. And, we are asking our customers, industry partners and others to do the same.

- If you're as concerned about this as we are, I challenge you to get involved. Mobilize your customers and employees to write a letter or call Gov. Chiles and ask him to veto S.B. 244, which is direct access for dermatologists.

- If we don't all get involved, legislation of this type could stop the progress we have made in helping more Floridians lead healthier, productive lives by expanding access to quality, affordable health care. At the same time, we recognize these bills don't get to the legislature because everything is perfect. And, there is certainly some responsibility for managed care to deal with these issues in a global and effective way.

- At Blue Cross and Blue Shield, we also are building on our ability to serve Floridians' needs for quality, affordable health care by making changes in the *way* we do business.

- Not too long ago, we announced a redesign initiative that will improve our ability to serve customers today as well as position us to exceed customers' expectations in the future.

- The redesigned organization structure reconfigures our five current regions into three geographic business units — or GBUs — with main offices in Jacksonville for North Florida, Orlando for Central Florida and Miami for South Florida.

    * Hopefully, you've already heard this news. In the North GBU, Ernie Brodsky has been appointed as the Sr. Vice President in charge of our north Florida operations.

- These GBUs will serve as the primary focus for running our day-to-day business operations. The rest of the organization supports these geographic units. The role of the traditional, functional organization is primarily to develop strategy and policy that will allow us to be effective in meeting — and exceeding — our customers needs and expectations.

- The new structure also aligns the company's key functions more closely to our customers and will help us strengthen our relationships with provider partners in each of the specific areas.

Conclusion

- We are excited about the opportunities ahead — although we realize that with every opportunity there are also challenges.

- As the health care industry continues to evolve and consolidate, we anticipate the Florida market will be dominated by 3 to 5 major players that are predominantly managed care companies.

- If that happens, we intend to be one of those companies. And, to do that, we are making the changes and investments necessary to provide Floridians with quality, cost-effective health plans that focus on prevention, early disease detection, greater quality of life and coordinated care between personal physicians and specialists.

- We will meet these future challenges and customer expectations through innovative products and capabilities that provide our customers with more value for their health care dollars.

- Thank you.